Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: SPARS SURGICAL 4126 SOUTHWEST FREEWAY, SUITE 200 HOUSTON, TX 77027	MFDR Tracking #: M4-11-2612-01
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Carrier's Austin Representative Box #: ULLICO CASUALTY CO Box #: 48	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: ""The above referenced claim was denied despite the fact that verification of benefits and/or preauthorization dated June 21, 2010 of care was obtained. Please be advised , our clinic relies on information received from your company regarding coverage. We extended treatment in good faith based on the expectation of payment as quoted and pre authorized by your company. In accordance with the Texas Workers' Compensation Commission rules 134.600; (a) 7, C, B, Preauthorization, Concurrent Review, and Voluntary Certification of Health Care, The {sic} carrier is liable for all reasonable and necessary medical costs relating to the health care if preauthorization is obtained. For your review, we are enclosing the copy of preauthorization letter, including copy of EOR, copy of the original bill, Operative Report and Implant Invoice. After numerous calls (16), I received a call from Kathy from the review Department (ASC) and {sic} asked us to resend the claim for review and processing. Once again this claim was denied. I proceded {sic} to contact m {sic} the treating Doctor Marcos Masson and to my surprise the **professional claim was paid in the amount of $2566.73 on 8/20/2010** and as the Facility we are still having difficulties in receiving payment. Based on this information, Spars is requesting medical dispute resolution since Spars is still dissatisfied with the insurance carrier's determination on the claim".

Amount in Dispute: $55,041.26

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

The respondent did not respond to this dispute.

Response Submitted by: N/A

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
6/29/10	29827	N/A	$15,897.74	$0.00
6/29/10	29826	N/A	$15,897.74	$0.00
6/29/10	29824	N/A	$1,587.74	$0.00
6/29/10	64415	N/A	$1,587.74	$0.00
6/29/10	L8699	N/A	$1,587.74	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of health care.
3. 28 Tex. Admin. Code §133.250 sets out the guidelines for reconsideration for payment of medical bills.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 9/29/2010

   - 216 – Based on findings of a review organization
   - Unnecessary medical treatment based on peer review.

Issues

1. Did the requestor submit sufficient documentation that the disputed services were sent to the insurance carrier for reconsideration in accordance with 28 Tex. Admin. Code §133.250 prior to sending the dispute to medical fee dispute resolution?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor submitted only one page of a two page explanation of benefit (EOB) in this dispute. Pursuant to rule §133.307(c)(2)(B) Provider Requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. The request shall include: a copy of each explanation of benefits (EOB), in a paper explanation of benefits format, relevant to the fee dispute **or**, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB. Under rule §133.250(d)(1-4) The request for reconsideration shall: reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill; include a copy of the original explanation of benefits, if received, or documentation that a request for an explanation of benefits was submitted to the insurance carrier; include any necessary and related documentation not submitted with the original medical bill to support the health care provider's position; and include a bill-specific, substantive explanation in accordance with §133.3 of this chapter (relating to Communication Between Health Care Providers and Insurance Carriers) that provides a rational basis to modify the previous denial or payment. The requestor did not submit any documentation providing evidence of carrier receipt of the request for reconsideration of payment of the medical bill. The Division made several attempts to contact the requestor contact, Sylvia Laudick for the missing information including an email submitted on 5/23/2011, and two telephone calls made on 6/14/2011 and 6/16/2011, leaving messages but no response was received. In absence of the reconsideration EOB and the absence of the respondent responding to this medical fee dispute, the Division is unable to determine if the requestor submitted the disputed bill to the insurance carrier for reconsideration and therefore concludes that the requestor did not submit this dispute in accordance with rules §133.250 and §133.307 and reimbursement to the requestor for the above date of service is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

		6/29/11
Authorized Signature	Medical Fee Dispute Resolution Officer	Date
		6/29/11
Authorized Signature	Medical Fee Dispute Resolution Manager	Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.